

117TH CONGRESS  
2D SESSION

# H. R. 1916

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IN THE SENATE OF THE UNITED STATES

APRIL 5, 2022

Received; read twice and referred to the Committee on Health, Education,  
Labor, and Pensions

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## AN ACT

To provide health insurance benefits for outpatient and inpatient items and services related to the diagnosis and treatment of a congenital anomaly or birth defect.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

**1 SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Ensuring Lasting  
3 Smiles Act”.

**4 SEC. 2. COVERAGE OF CONGENITAL ANOMALY OR BIRTH  
5 DEFECT.**

6 (a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—  
7 Part D of title XXVII of the Public Health Service Act  
8 (42 U.S.C. 300gg–111 et seq.) is amended by adding at  
9 the end the following new section:

**10 “SEC. 2799A-11. STANDARDS RELATING TO BENEFITS FOR  
11 CONGENITAL ANOMALY OR BIRTH DEFECT.**

12 “(a) REQUIREMENTS FOR CARE AND RECONSTRUC-  
13 TIVE TREATMENT.—

14 “(1) IN GENERAL.—A group health plan, and a  
15 health insurance issuer offering group or individual  
16 health insurance coverage, shall provide coverage for  
17 outpatient and inpatient items and services related  
18 to the diagnosis and treatment of a congenital  
19 anomaly or birth defect.

20 “(2) REQUIREMENTS.—

21 “(A) IN GENERAL.—Coverage provided  
22 under paragraph (1) shall include any medically  
23 necessary item or service to functionally im-  
24 prove, repair, or restore any body part to  
25 achieve normal body functioning or appearance,  
26 as determined by the treating physician (as de-

3                     “(B) FINANCIAL REQUIREMENTS AND  
4 TREATMENT REQUIREMENTS.—Any coverage  
5 provided under paragraph (1) under a group  
6 health plan or individual or group health insur-  
7 ance coverage offered by a health insurance  
8 issuer may be subject to coverage limits (such  
9 as medical necessity, pre-authorization, or pre-  
10 certification) and cost-sharing requirements  
11 (such as coinsurance, copayments, and  
12 deductibles), as required by the plan or issuer,  
13 that are no more restrictive than the predomi-  
14 nant coverage limits and cost-sharing require-  
15 ments, respectively, applied to substantially all  
16 medical and surgical benefits covered by the  
17 plan (or coverage).

18               “(3) TREATMENT DEFINED.—In this section:

19                 “(A) IN GENERAL.—Except as provided in  
20                 subparagraph (B), the term ‘treatment’ in-  
21                 cludes, with respect to a group health plan or  
22                 group or individual health insurance coverage  
23                 offered by a health insurance issuer, inpatient  
24                 and outpatient items and services performed to  
25                 improve, repair, or restore bodily function (or

1           performed to approximate a normal appear-  
2           ance), due to a congenital anomaly or birth de-  
3           fect, and includes treatment to any and all  
4           missing or abnormal body parts (including  
5           teeth, the oral cavity, and their associated  
6           structures) that would otherwise be provided  
7           under the plan or coverage for any other injury  
8           or sickness, including—

9                 “(i) any items or services, including  
10                inpatient and outpatient care, reconstruc-  
11                tive services and procedures, and complica-  
12                tions thereof;

13                 “(ii) adjunctive dental, orthodontic, or  
14                prosthetic support from birth until the  
15                medical or surgical treatment of the defect  
16                or anomaly has been completed, including  
17                ongoing or subsequent treatment required  
18                to maintain function or approximate a nor-  
19                mal appearance;

20                 “(iii) procedures that materially im-  
21                prove, repair, or restore bodily function;  
22                and

23                 “(iv) procedures for secondary condi-  
24                tions and follow-up treatment associated

with the underlying congenital anomaly or birth defect.

3                   “(B) EXCEPTION.—The term ‘treatment’  
4       shall not include cosmetic surgery performed to  
5       reshape normal structures of the body to im-  
6       prove appearance or self-esteem.

7       “(b) NOTICE.—Not later than one year after the date  
8 of the enactment of this section and annually thereafter,  
9 a group health plan, and a health insurance issuer offering  
10 group or individual health insurance coverage, shall, in ac-  
11 cordance with regulations or guidance issued by the Sec-  
12 retary, provide to each enrollee under such plan or cov-  
13 erage a written description of the terms of this section.  
14 Such description shall be in language which is understand-  
15 able to the typical enrollee.”.

21 "SEC. 726. STANDARDS RELATING TO BENEFITS FOR CON-  
22 GENITAL ANOMALY OR BIRTH DEFECT.

23        "(a) REQUIREMENTS FOR CARE AND RECONSTRUC-  
24        TIVE TREATMENT —

1           “(1) IN GENERAL.—A group health plan, and a  
2        health insurance issuer offering group health insur-  
3        ance coverage, shall provide coverage for outpatient  
4        and inpatient items and services related to the diag-  
5        nosis and treatment of a congenital anomaly or birth  
6        defect.

7           “(2) REQUIREMENTS.—

8           “(A) IN GENERAL.—Coverage provided  
9        under paragraph (1) shall include any medically  
10        necessary item or service to functionally im-  
11        prove, repair, or restore any body part to  
12        achieve normal body functioning or appearance,  
13        as determined by the treating physician (as de-  
14        fined in section 1861(r) of the Social Security  
15        Act), due to congenital anomaly or birth defect.

16           “(B) FINANCIAL REQUIREMENTS AND  
17        TREATMENT REQUIREMENTS.—Any coverage  
18        provided under paragraph (1) under a group  
19        health plan or group health insurance coverage  
20        offered by a health insurance issuer may be  
21        subject to coverage limits (such as medical ne-  
22        cessity, pre-authorization, or pre-certification)  
23        and cost-sharing requirements (such as coinsur-  
24        ance, copayments, and deductibles), as required  
25        by the plan or issuer, that are no more restric-

1 tive than the predominant coverage limits and  
2 cost-sharing requirements, respectively, applied  
3 to substantially all medical and surgical benefits  
4 covered by the plan (or coverage).

5 “(3) TREATMENT DEFINED.—In this section:

6 “(A) IN GENERAL.—Except as provided in  
7 subparagraph (B), the term ‘treatment’ in-  
8 cludes, with respect to a group health plan or  
9 group health insurance coverage offered by a  
10 health insurance issuer, inpatient and out-  
11 patient items and services performed to im-  
12 prove, repair, or restore bodily function (or per-  
13 formed to approximate a normal appearance),  
14 due to a congenital anomaly or birth defect, and  
15 includes treatment to any and all missing or ab-  
16 normal body parts (including teeth, the oral  
17 cavity, and their associated structures) that  
18 would otherwise be provided under the plan or  
19 coverage for any other injury or sickness, in-  
20 cluding—

21 “(i) any items or services, including  
22 inpatient and outpatient care, reconstruc-  
23 tive services and procedures, and complica-  
24 tions thereof;

1                         “(ii) adjunctive dental, orthodontic, or  
2                         prosthetic support from birth until the  
3                         medical or surgical treatment of the defect  
4                         or anomaly has been completed, including  
5                         ongoing or subsequent treatment required  
6                         to maintain function or approximate a nor-  
7                         mal appearance;

8                         “(iii) procedures that materially im-  
9                         prove, repair, or restore bodily function;  
10                         and

11                         “(iv) procedures for secondary condi-  
12                         tions and follow-up treatment associated  
13                         with the underlying congenital anomaly or  
14                         birth defect.

15                         “(B) EXCEPTION.—The term ‘treatment’  
16                         shall not include cosmetic surgery performed to  
17                         reshape normal structures of the body to im-  
18                         prove appearance or self-esteem.

19                         “(b) NOTICE.—Not later than one year after the date  
20                         of the enactment of this section and annually thereafter,  
21                         a group health plan, and a health insurance issuer offering  
22                         group health insurance coverage, shall, in accordance with  
23                         regulations or guidance issued by the Secretary, provide  
24                         to each participant or beneficiary under such plan or cov-  
25                         erage a written description of the terms of this section.

1 Such description shall be in language which is understand-  
2 able to the typical participant or beneficiary.”.

3 (2) TECHNICAL AMENDMENT.—The table of  
4 contents in section 1 of such Act is amended by in-  
5 serting after the item relating to section 725 the fol-  
6 lowing new item:

“Sec. 726. Standards relating to benefits for congenital anomaly or birth de-  
fect.”.

7 (c) INTERNAL REVENUE CODE AMENDMENTS.—

8 (1) IN GENERAL.—Subchapter B of chapter  
9 100 of the Internal Revenue Code of 1986 is amend-  
10 ed by adding at the end the following:

11 **SEC. 9826. STANDARDS RELATING TO BENEFITS FOR CON-**  
12 **GENITAL ANOMALY OR BIRTH DEFECT.**

13 “(a) REQUIREMENTS FOR CARE AND RECONSTRUC-  
14 TIVE TREATMENT.—

15 “(1) IN GENERAL.—A group health plan shall  
16 provide coverage for outpatient and inpatient items  
17 and services related to the diagnosis and treatment  
18 of a congenital anomaly or birth defect.

19 “(2) REQUIREMENTS.—

20 “(A) IN GENERAL.—Coverage provided  
21 under paragraph (1) shall include any medically  
22 necessary item or service to functionally im-  
23 prove, repair, or restore any body part to  
24 achieve normal body functioning or appearance,

1           as determined by the treating physician (as de-  
2           fined in section 1861(r) of the Social Security  
3           Act), due to congenital anomaly or birth defect.

4           “(B) FINANCIAL REQUIREMENTS AND  
5           TREATMENT REQUIREMENTS.—Any coverage  
6           provided under paragraph (1) under a group  
7           health plan may be subject to coverage limits  
8           (such as medical necessity, pre-authorization, or  
9           pre-certification) and cost-sharing requirements  
10          (such as coinsurance, copayments, and  
11          deductibles), as required by the plan, that are  
12          no more restrictive than the predominant cov-  
13          erage limits and cost-sharing requirements, re-  
14          spectively, applied to substantially all medical  
15          and surgical benefits covered by the plan.

16          “(3) TREATMENT DEFINED.—In this section:

17           “(A) IN GENERAL.—Except as provided in  
18           subparagraph (B), the term ‘treatment’ in-  
19           cludes, with respect to a group health plan, in-  
20           patient and outpatient items and services per-  
21           formed to improve, repair, or restore bodily  
22           function (or performed to approximate a normal  
23           appearance), due to a congenital anomaly or  
24           birth defect, and includes treatment to any and  
25           all missing or abnormal body parts (including

1           teeth, the oral cavity, and their associated  
2           structures) that would otherwise be provided  
3           under the plan for any other injury or sickness,  
4           including—

5                 “(i) any items or services, including  
6                 inpatient and outpatient care, reconstruc-  
7                 tive services and procedures, and complica-  
8                 tions thereof;

9                 “(ii) adjunctive dental, orthodontic, or  
10                 prosthetic support from birth until the  
11                 medical or surgical treatment of the defect  
12                 or anomaly has been completed, including  
13                 ongoing or subsequent treatment required  
14                 to maintain function or approximate a nor-  
15                 mal appearance;

16                 “(iii) procedures that materially im-  
17                 prove, repair, or restore bodily function;  
18                 and

19                 “(iv) procedures for secondary condi-  
20                 tions and follow-up treatment associated  
21                 with the underlying congenital anomaly or  
22                 birth defect.

23                 “(B) EXCEPTION.—The term ‘treatment’  
24                 shall not include cosmetic surgery performed to

1           reshape normal structures of the body to im-  
2           prove appearance or self-esteem.

3        “(b) NOTICE.—Not later than one year after the date  
4  of the enactment of this section and annually thereafter,  
5  a group health plan shall, in accordance with regulations  
6  or guidance issued by the Secretary, provide to each en-  
7  rollee under such plan a written description of the terms  
8  of this section. Such description shall be in language which  
9  is understandable to the typical enrollee.”.

10       (2) CLERICAL AMENDMENT.—The table of sec-  
11  tions for such subchapter is amended by adding at  
12  the end the following new item:

“Sec. 9826. Standards relating to benefits for congenital anomaly or birth de-  
fect.”.

13       (d) RULE OF CONSTRUCTION.—A group health plan  
14  or health insurance issuer shall provide the benefits de-  
15  scribed in section 2799A–11 of the Public Health Service  
16  Act (as added by subsection (a)), section 726 of the Em-  
17  ployee Retirement Income Security Act of 1974 (as added  
18  by subsection (b)), and section 9826 of the Internal Rev-  
19  enue Code of 1986 (as added by subsection (c)) under the  
20  terms of such plan or health insurance coverage offered  
21  by such issuer.

22       (e) EFFECTIVE DATE.—The amendments made by  
23  this section shall apply with respect to plan years begin-  
24  ning on or after January 1, 2024.

1   **SEC. 3. DETERMINATION OF BUDGETARY EFFECTS.**

2       The budgetary effects of this Act, for the purpose of  
3   complying with the Statutory Pay-As-You-Go Act of 2010,  
4   shall be determined by reference to the latest statement  
5   titled “Budgetary Effects of PAYGO Legislation” for this  
6   Act, submitted for printing in the Congressional Record  
7   by the Chairman of the House Budget Committee, pro-  
8   vided that such statement has been submitted prior to the  
9   vote on passage.

Passed the House of Representatives April 4, 2022.

Attest:                   **CHERYL L. JOHNSON,**  
*Clerk.*